

WITH UNFADING INK---THIS IS A PERMANENT RECORD  
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH **Buchanan** 85  
 County ..... Registration District No. .... 258  
 Township ..... Primary Registration District No. **1001**  
 City **St. Joseph Mo.,** (No. **1219 1/2** N, 3rd) ..... St. .... Ward) .....  
 2. FULL NAME **Mrs Mattie Shoemaker**  
 (a) Residence, No. **1219 1/2 N 3rd** ..... St. .... Ward.  
 (Usual place of abode) ..... (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Female</b>	4. COLOR OR RACE <b>Colored</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <b>Widow</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>Nov 24, 1862</b>		
7. AGE	YEARS <b>71</b>	MONTHS <b>1</b>
	DAYS <b>23</b>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <b>Housewife</b>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Data deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Clinton Mo</b>		
MOTHER	13. NAME <b>Unknown</b>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Unknown Unknown</b>	
	15. MAIDEN NAME <b>Unknown</b>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <b>Unknown Unknown</b>	
17. INFORMANT <b>John Gene Shoemaker</b> (ADDRESS) <b>1219 1/2 N 3rd St</b>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>City Cem</b> DATE <b>1-20-34</b>		
19. UNDERTAKER <b>B. F. Graves Funeral Home</b> (ADDRESS) <b>806 South 17th St</b>		
20. FILED <b>1-19-34</b> <b>John R. Berard</b> Registrar		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 17, 1934**

I HEREBY CERTIFY, That **deceased** deceased from **Jan 16, 1934**, to **Jan 17, 1934**, 19.....  
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at **9:30 A.** m.  
 The principal cause of death and related causes of importance were as follows:  
**Cerebral Hemorrhage** Date of onset  
**Arteriosclerosis**

Other contributory causes of importance:  
**Arteriosclerosis**

Name of operation **none** Date of.....  
 What test confirmed diagnosis? **Allen Test** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? **no** Date of injury....., 19.....  
 Where did injury occur? **none**  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **none** **did it from I no injury**  
 Nature of injury **none**

24. Was disease or injury in any way related to occupation of deceased? **no**  
 If so, specify.....  
 (Signed) **Thomas Thomas** Coroner **M.D.**  
 (Address) **80 1/2 Kelly**

